U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 05 April 2005

CASE NO.: 2003-BLA-6713

In the Matter of

FRED R. JENKINS,
Claimant

v.

PEABODY COAL COMPANY,
Employer

and

OLD REPUBLIC INSURANCE COMPANY
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Larry R. Rowe, Esq.,
For the Claimant

Paul E. Frampton, Esq.,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER - DENYING BENEFITS

This proceeding arises from a miner's claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"), filed on December 14, 2001, respectively. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal worker's pneumoconiosis" ("CWP") as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The claimant filed his claim for benefits on December 14, 2001. (Director's Exhibit ("DX") 2). The claim was approved by the district director because the evidence established the elements of entitlement that Mr. Jenkins has coal workers' pneumoconiosis and he is totally disabled due to pneumoconiosis. (DX 30). On June 16, 2003, the employer requested a hearing before an administrative law judge. (DX 31). On September 25, 2003, the case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Program (OWCP) for a formal hearing. (DX 36). I was assigned the case on February 27, 2004.

On August 5, 2004, I held a hearing in Charleston, West Virginia, at which time the claimant and the employer were represented by counsel.[1] No appearance was entered for the Director, Office of Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. Claimant's exhibits ("CX") 1-8, Director's exhibits ("DX") 1-38, and Employer's exhibits ("EX") 1-11 were admitted into the record.

Post-hearing evidence consists of exhibits EX 12 and 13 and CX 9. At the time of hearing in this matter, I provided the employer with thirty days to respond to the reports of Drs. Rasmussen and Vidal. (CX 7 and 8). Under cover letter, dated October 1, 2004, the employer submitted the opinions of Drs. Branscomb and Zaldivar. Both of these supplemental opinions address the opinion of Dr. Rasmussen. No objection was received to the admission of this evidence. I have admitted these additional reports. Under cover letter, dated November 17, 2004, the claimant submitted Dr. Rasmussen's response to the supplemental opinions of Drs. Branscomb and Zaldivar. There was no objection to the admission of this evidence. I admitted have this report to the record in this matter. Therefore EX 12 and 13 and CX 9 are admitted to the record in this matter. The closing statements of both parties have also been admitted to the record in this matter.

ISSUES

I. Whether the miner has pneumoconiosis as defined by the Act and the Regulations?

[1] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction. Under *Kopp v. Director, OWCP*, 877 F.2D 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction.

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner is totally disabled due to pneumoconiosis?

FINDINGS OF FACT

I. Background

A. Coal Miner

The claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least 18 years. (Hearing Transcript (TR) 8).

B. Date of Filing

The claimant filed his claim for benefits, under the Act, on December 14, 2001. (DX 2). None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

C. Responsible Operator

Peabody Coal Company is the last employer for whom the claimant worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart G for claims filed on or after Jan. 19, 2001, Part 725 of the Regulations. (TR 9).

D. Dependents

The claimant has one dependent for purposes of augmentation of benefits under the Act, his wife Mary Ann Landry Jenkins. (DX 10; TR 9).

E. Personal, Employment and Smoking History[2]

The claimant was born on May 1, 1949. (DX 2). He married Mary Ann Landry on December 22, 1977. (DX 10). The Claimant's last position in the coal mines was that of a general inside laborer. (DX 5). Claimant described his last employment in the coal mines as that of a shuttle car operator. (DX 5). However, his employment history was provided by Employer indicating his dates of service and the jobs for which he was employed. (DX 6). The employer indicates that the claimant was last employed in the coal mines in August 1991 and was placed on "lay off disability status on December 31, 1991." (DX 6). The claimant's own employment worksheet indicates that his last coal mining job ended on August 22, 1991, but later in that same document, he states that he worked until November 1992. (DX 5).

The claimant indicates that his last job was as a shuttle car operator. (DX 5). However, he later explains in the section where he defines his duties that as a general inside laborer, he was

[2] "The BLBA, judicial precedent, and the program regulations do not permit an award based solely upon smoking-induced disability." 65 Fed. Reg. 79948, No. 245 (Dec. 20, 2000).

required to perform certain duties. Therefore, I find that the claimant's last job in the coal mining industry was as a general inside laborer from March 13, 1990 through August 22, 1991. (DX 6). This finding does not change the fact that the claimant's last work in the coal mining industry would be considered heavy manual labor. While I do not find that the claimant accurately stated his specific job title, I do find that his description of his job duties is accurate.

He was employed in one or more underground mines for fifteen years or more. The claimant, as part of his duties, was required to work at the face of the mine. (DX5). In addition to working at the face of the mine, the claimant would set timbers and hang curtain. (DX 5). The claimant further described his position as a general inside laborer to be doing "whatever the bosses wanted done." (DX 5). The claimant estimated that as a part of his duties, he would be required to lift 100 pounds approximately 20 times per day, as well as lesser amounts numerous times during a shift. (DX 5). Carrying various weights was also required. The claimant estimates that he carried 100 pounds three times per day, 75 pounds fifty times per day and 50 pounds fifty times per day. (DX 5).

There is evidence of record that the claimant's respiratory disability is due, in part, to his history of cigarette smoking. The evidence is conflicting concerning the miner's smoking history. However, I find he smoked from 1968 to 1987 at a rate of one pack of cigarettes per day for a nineteen pack year history. Since 1987, I find that the claimant has smoked one pipe per day continuing to the present.

I base this finding on the documented smoking histories contained in the record in this matter. Dr. Rasmussen notes that the claimant began smoking cigarettes in 1966 and quit in 1985. He then indicated that the claimant was currently smoking a pipe, although the claimant stated that the pipe was "seldom lit." (DX 13 & CX 7). In his notations, Dr. Gaziano noted that the claimant smoked cigarettes from 1968 to 1987 and one cigar per day from 2000 until 2004. (CX 1). Dr. Zaldivar's reports noted that the claimant began smoking cigarettes as a teenager and quit in 1987. (EX 8). Dr. Zaldivar's reports state a rate of one and one-half packs per day. Dr. Zaldivar further reported that the claimant began smoking a pipe in 1987 and continued that behavior to the present time. (EX 8). In his July 8, 2004 examination of the claimant, Dr. Branscomb noted that the claimant's carboxyhemoglobin level was that of a person smoking over one pack of cigarettes per day. (EX 9).

Based on the foregoing information, I have determined that the claimant smoking history is that of smoking one pack of cigarettes per day for 19 years, ending in 1987. At that time, the claimant began to smoke one pipe per day and that the claimant continues that behavior to the present time.

II. Medical Evidence[3]

A. Chest X-rays[4]

There are nine readings of eight X-rays, taken on May 26, 2004; March 4, 2004; July 1, 2003; June 30, 2003; September 3, 2002; September 2, 2002; April 10, 2002; and January 16, 1992. (DX 18 and 19; CX 2 & 5; and EX 1 through 3). Seven of the readings are properly classified for pneumoconiosis, pursuant to 20 C.F.R. § 718.102(b).[5] Two are positive, by two physicians, Dr. Patel who is Board-certified in radiology and is a B-reader; and Dr. Gaziano who is Board-certified in internal medicine with a sub-specialty of pulmonary disease and is a B-reader.[6] Five are negative, by three physicians, Drs. Wheeler, Scott and Scatarige, all of whom are either B-readers, Board-certified in radiology, or both. The remaining negative impressions were rendered by Dr. Branscomb who is Board-certified in internal medicine and is a B-reader. The remaining two x-rays were taken in connection with a hospital stay at St. Francis Hospital. The interpretations make no specific finding regarding the existence of pneumoconiosis.

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
EX 2	5/26/04 6/4/04	Wheeler	BCR, B	1	Negative	Chest PA- obesity. Check body mass index/obesity risks serious diseases. No other abnormality. Approximate CTR: 13.5/35.5 excluding cardiophrenic angle fat pad.
CX 2	3/4/04 3/4/04	Gaziano	BCI(P), B	1	1/1; q/p	Nothing noted
CX 5	7/1/03 7/1/03	Vidal	Unknown	Performed during	Not noted	Findings showed there is rounded density seen in the

[3] *Dempsey v. Sewell Coal Co. & Director, OWCP*, 23 B.L.R. 1-53, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). BRB upheld regulatory limitations on the admissibility of medical evidence, under the new 2001 regulations, i.e., 20 C.F.R. Sections 725.414 and 725.456(b)(1).

[4] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e)(effective Jan. 19, 2001).

[5] ILO-UICC/Cincinnati classification of Pneumoconiosis – The most widely used system for the classification and interpretation of X-rays for the disease pneumoconiosis. This classification scheme was originally devised by the International Labor Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs.

[6] *LaBelle Processing Co. v. Swarrow,* 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading x-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to X-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993)."

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
				hospital stay		right lung apex not appreciated on prior imaging. Raises concern for underlying mass and CT of the chest therefore strongly advised.
CX 5	6/30/03 6/30/03	Vidal	Unknown	Performed during hospital stay	Not noted	Minimal chronic changes and mild lung congestion, suspect minimal right basilar infiltration
DX 18	9/3/02 9/3/02	Patel	BCR, B	2	1/1; s/p	Nothing noted
DX 19	9/2/02 10/23/02	Gaziano	BCI(P), B	1		Read for quality only
EX 3	9/3/02 2/26/03	Scott	BCR, B	2	Negative	Negative reading for pneumoconiosis
EX 1	4/10/02 4/17/02	Scatarige	BCR, B	3	Negative	Negative reading for pneumoconiosis
EX 9	4/10/02 7/7/04	Branscomb	BCI, B	2	Negative	Few calcifications in the hilar nodes
EX 9	1/16/92 7/7/04	Branscomb	BCI,B	2	Negative	Generalized hazy increase in markings caused by obesity. Note the lower corner of the left lung: Pseudogynecomastia is present due to obesity. The lower edge of it is well demarcated. Above this delineation the hazy increase is quite evident. Below the line, unobscured by fat, the corner of the lung is quite clear.

* A-A-reader; B-B-Reader; BCR – Board Certified Radiologist; BCP – Board-certified pulmonologist; BCI – Board-certified internal medicine; BCI(P) – Board-certified internal medicine with pulmonary medicine sub-specialty. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987) and, *Old Ben Coal Co. v. Battram,* 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993). B-readers need not be radiologists.

**The existence of pneumoconiosis may be established by chest X-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest X-ray classified as category "0," including subcategories "0/-, 0/0, 0/1," does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp*., 6 B.L.R. 1-307 (1983) (Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997)(*en banc)(Unpublished)*. If no categories are chosen, in box 2B(c) of the X-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.

CT Scans

The record contains the results of three CT scans two of which were read by Board Certified Radiologists**,** one of which was read by a physician whose credentials are unknown and one which was read by a B-reader. They show various results. A CAT scan falls into the "other means" category of 20 C.F.R. § 718.304(c) rather than being considered an X-ray under § 718.304(a). A CAT scan is "computed tomography scan or computer aided tomography scan. Computed tomography involves the recording of 'slices' of the body with an x-ray scanner (CT scanner). These records are then integrated by computer to give a cross-sectional image. The technique produces an image of structures at a particular depth within the body, bringing them into sharp focus while deliberately blurring structures at other depths. *See,* THE BANTAM MEDICAL DICTIONARY, 96, 437 (Rev. Ed. 1990)." *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991). In *Consolidation Coal C. v. Director, OWCP [Stein]*, ___ F.3d ___, 22 B.L.R. 2-409, 2002 WL 1363785 (7th Cir. June 25, 2002), the Court rejected the employer's argument that a negative CT is conclusive evidence the miner does not have pneumoconiosis. The DOL has rejected such a view. Nor should a negative CT be given controlling weight because the statutory definition of "pneumoconiosis" encompasses a broader spectrum of diseases than those pathological conditions which can be detected by clinical test such as X-rays and CT scans.

There are three CT scans included in the record in this matter. The first, dated, February 3, 2003, was read by both Drs. Wheeler and Branscomb. Dr. Wheeler is a Board-certified radiologist. Dr. Wheeler found the scan to be of good quality showing no pneumoconiosis. (EX 10). Dr. Wheeler noted that the scan indicated focal arteriosclerosis proximal coronary arteries and minimal emphysema in the upper lobes. There was also an "8 mm nodule posterior right apex compatible with granuloma more likely than tumor." Also reported in Dr. Wheeler's reading are "subtle interstitial fibrosis anterolateral periphery LUL and lingual. Small discoid atelectasis or scar lower lateral lingula." Lastly, Dr. Wheeler notes moderate obesity "including intraabdominal and mediastinal deposits."

Dr. Branscomb also interpreted the February 3, 2003 CT scan. Dr. Branscomb is Board-certified in internal medicine and is a B-reader. Dr. Branscomb stated that the CT scan showed "calcifications in nodes [and] marked obesity." (EX 9).

Another CT scan was done on July 2, 2003 while the claimant was admitted to St. Francis Hospital. (CX 5). The person reading the CT scan is unknown; however, it was read to show a "stable parenchymal nodule in the right upper lobe as compared to the study of 1998. There is underlying emphysema."

The third CT scan was taken on May 26, 2004 and was interpreted by Dr. Scott. Dr. Scott is a Board-certified radiologist. Dr. Scott's interpretation stated that the claimant has emphysema is his upper lungs and that he is obese. (EX 10). Dr. Scott noted "minimal non-specific linear interstitial fibrosis in the lung periphery – probably UIP." Dr. Scott found no evidence of coal workers' pneumoconiosis or silicosis.

B. Pulmonary Function Studies[7]

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

Physician **Date** **Exh.#**	**Age** **Height**	**FEV_1***	**MVV**	**FVC**	**Tracings**	**Comprehension** **Cooperation**	**Qualify **** **Conform *****	**Dr.'s Impression**
Zaldivar 5/26/04 EX 5	55 68	2.14 2.37	Not noted Not noted	3.85 3.77	Yes	Not noted Not noted	No Yes	Moderate irreversible obstruction; mild restriction; moderate diffusion impairment; high carboxyhemoglobin of a smoker
Gaziano 3/4/04 CX 4	54 69	2.49 2.54	77 Not noted	3.92 4.03	Yes	Not noted Not noted	No Yes	Mild irreversible obstructive ventilatory impairment. Reduced lung volumes. Moderate diffusion impairment.

[7] § 718.103(a)(Effective for tests conducted after Jan. 19, 2001 (See 718.101(b)), provides: "Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop)." 65 Fed. Reg. 80047 (Dec. 20, 2000). In the case of a deceased miner, where no pulmonary function test are in substantial compliance with paragraphs (a) and (b) and Appendix B, noncomplying tests may form the basis for a finding if, in the opinion of the adjudication officer, the tests demonstrate technically valid results obtained with good cooperation of the miner. 20 C.F.R. § 718.103(c).

Rasmussen 9/3/02 DX 17	53 67	2.67 2.71	55 59	3.97 4.07	Yes	Good Good	No Yes	Slight irreversible obstructive impairment
Zaldivar 4/10/02 EX 4	52 68	2.79 2.92	89 89	4.44 4.43	Yes	Not noted Not noted	No Yes	Mild irreversible obstruction; normal lung volume; moderate diffusion improve-ment; high carboxyhe-moglobin of a smoker

* The values contained in the second row of the FEV_1, MVV and FVC columns are the results of testing after the administration of bronchodilators.

**A "qualifying" pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

*** A study "conforms" if it complies with applicable standards (found in 20 C.F.R. § 718.103(b) and (c)). (*See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 (7th Cir. 1993)). A judge may infer in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP,* 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

Appendix B (Effective Jan. 19, 2001) states "(2) the administration of pulmonary function tests shall conform to the following criteria: (i) Tests shall not be performed during or soon after an acute respiratory illness…"

Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed "unacceptable" when the subject "[H]as an excessive variability between the three acceptable curves. The variation between the two largest FEV_1'S of the three acceptable tracings should not exceed 5 percent of the largest FEV_1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve the degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test." (Emphasis added).

For a miner of the claimant's height of 68 inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 1.99 for a male 55 years of age.[8] If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.51 or an MVV equal to or less than 79; or a ratio equal to or less than 55% when the results of the FEV_1 tests are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table below. The FEV_1/FVC ration requirement remains constant.

[8] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Associated Coal Co.*, 42 F.3d 3 (4th Cir. 1995). I find the miner is 68" here, the most often reported height as well as his average reported height.

Height	Age	FEV_1	FVC	MVV
69"	54	2.06	2.61	83
67"	53	1.92	2.43	77
68"	52	2.03	2.57	81

C. Arterial Blood Gas Studies[9]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Ex. #	Physician	PCO2	PO2	Qualify	Physician Impression
5/26/04 EX 7	Zaldivar	36	68	No	Nothing noted on report.
3/4/04 CX 3	Gaziano	33	68	No	Moderate decreased arterial oxygen tension at rest.
6/30/03 CX 5	Vidal	38	97	No	Nothing noted on report.
9/3/02 DX 14	Rasmussen	36	48	Yes	Mild resting hypoxemia
9/3/02 DX 15	Gaziano	Not noted	Not noted		Read for quality only. Found to be of acceptable quality.
4/10/02 EX 6	Zaldivar	31 34*	82 61*	No Yes	Exercise stopped due to dizziness; shows moderate to severe exercise impairment due to hypoxemia brought about by diffusion abnormalities and V/Q mismatch.

*Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b).

Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respirator or cardiac illness."

[9] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. §718.204(b)(2) permits the use of such studies to establish "total disability." It provides: In the absence of contrary probative evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability:…
(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part…

D. Physicians' Reports[10]

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(A)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. D.L. Rasmussen, is a B-reader and is Board-certified in internal medicine and forensic medicine. His examination report, based upon his examination of the claimant, on September 3, 2002, notes 21 years of coal mine employment and a 19-year cigarette smoking history as well as smoking a pipe since that time. (DX 13). Dr. Rasmussen described the claimant's symptoms as morning sputum production; wheezing at night especially after a day of exertion; dyspnea, significant after one flight of stairs; morning cough; remote hemoptysis; chest pain prior to gallbladder surgery; two pillow orthopnea; ankle edema; and paroxysmal nocturnal dyspnea.

At the time of his examination of the claimant, Dr. Rasmussen noted the work requirements for the claimant's last coal mine employment as a general inside laborer. Dr. Rasmussen categorized this employment as "considerable heavy manual labor." Dr. Rasmussen also considered the claimant's family medical history and the claimant's own prior medical history.

Based on arterial blood gases, a pulmonary function study, and a positive chest X-ray, Dr. Rasmussen diagnosed the claimant as suffering from coal workers' pneumoconiosis and chronic obstructive pulmonary disease. Dr. Rasmussen bases his diagnosis of coal workers' pneumoconiosis on the claimant's 19 plus years of coal mine employment and the positive chest X-ray reading.

He opined that the claimant's coal miners' pneumoconiosis was related to his coal dust exposure, and that the claimant's chronic obstructive pulmonary disease resulted from the claimant's coal mine employment as well as his smoking history. Dr. Rasmussen went on to state that the claimant suffers from "at least moderate loss of lung function … This percentage of impairment indicates the patient does not retain the pulmonary capacity to perform his last coal mine employment." Dr. Rasmussen went on to address that the claimant has two risk factors for the development of a pulmonary impairment: smoking history and coal dust exposure. Dr. Rasmussen opined that the claimant's coal dust exposure "seems more significant since his gas exchange impairment is greater than his insignificant ventilatory impairment. His coal dust exposure is the major contributing factor."

[10] *Dempsey v. Sewell Coal Co. & Director, OWCP*, 23 B.L.R. 1-53, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). Under the 2001 regulations, expert opinions must be based on admissible evidence.

Dr. Rasmussen also conducted a review of the claimant's medical records in this matter and offered an opinion, dated August 2, 2004. (CX 7). Dr. Rasmussen noted that the claimant began suffering from shortness of breath in the early 1990s with a progressive worsening of symptoms; a chronic productive cough and wheezing; and chest pain resulting in a cardiac catherization in 2002 with minimal findings. Dr. Rasmussen again noted a 19 ½ year coal mine employment history, with most of that work occurring at the face of the mine.

Dr. Rasmussen reiterated his prior finding as to the claimant's smoking history. Dr. Rasmussen took issue with Drs. Zaldivar's and Branscomb's finding indicating that the claimant's impairment is due to cardiovascular disease. He opined that there is insufficient clinical evidence to justify a diagnosis of congestive heart failure. Dr. Rasmussen bases this finding on the claimant's EKG that showed normal left ventricular size and function with a normal ejection fraction. He went on to state that there is "nothing to suggest that [the claimant] exhibited impaired cardiac function when he was evaluated by Dr. Zaldivar including no EKG changes and no evidence of early anaerobic metabolism." Based upon this evidence, Dr. Rasmussen rejects the conclusion that the cardiovascular disease plays a role in the claimant's impairment.

He went on to opine that although the claimant's smoking history is a contributing factor to the claimant's impairment, that the claimant does not exhibit the obstructive airway pattern that is usually associated with cigarette smoking induced lung impairment. Dr. Rasmussen stated that based on prior studies, he has concluded that cigarette smoking and coal dust exposure "act additively in causing impairment in gas exchange in coal miners."

He concluded that the claimant suffers from coal workers' pneumoconiosis which arose out of his coal mine employment. He further concluded that the claimant suffers from a "disabling chronic lung disease [as a result] of occupational dust exposure and cigarette smoking." However, Dr. Rasmussen believes that coal dust exposure is the major contributing factor to the claimant's disabling chronic lung disease.

Dr. Rasmussen offered a supplemental report, dated November 10, 2004 to respond to the supplemental reports offered by Drs. Branscomb and Zaldivar. (CX 9). Dr. Rasmussen stated that neither of these reports changes his opinion regarding the claimant's condition. Dr. Rasmussen again stated that a finding of congestive heart failure is not supported by the record because there is "no evidence demonstrating abnormal gas exchange." Additionally, there is no evidence that ventricular failure is a cause of the claimant's impairment.

Dr. Dominic Gaziano, is a B-reader-reader and is Board-certified in internal medicine with a subspecialty in pulmonary medicine. His examination report, based upon his examination of the claimant, on March 8, 2004, notes 21 years of coal mine employment and a 19-year cigarette smoking history and a history of smoking one cigar per day from 2000 through the date of the examination. (CX 1). Dr. Gaziano described the claimant's symptoms as a productive cough, shortness of breath with walking or climbing stairs and right anterior chest pain. Dr. Gaziano also noted that the claimant employed the use of oxygen at night.

Dr. Gaziano noted the claimant's employment history to include running a shuttle car, loading coal and operating a mine scooper.

Based on arterial blood gases, a pulmonary function study, and a positive chest X-ray, Dr. Gaziano diagnosed the existence of coal workers' pneumoconiosis.

He opined that the claimant's pulmonary condition is related to his coal dust exposure with a moderate degree of pulmonary function impairment.

Dr. Melchor Vidal whose qualifications are not in the record, stated that he has been the claimant's treating physician for nineteen years. (CX 6). His report, based upon his experience with the claimant, dated August 3, 2004 states that the claimant has been "treated and hospitalized … for pulmonary problems secondary to pneumoconiosis and chronic obstructive pulmonary disease." Dr. Vidal bases his conclusion that the claimant suffers from these conditions on the pulmonologists' findings as well as previous chest X-ray readings by radiologists. Dr. Vidal concluded by stating that he believes that the claimant suffers from pneumoconiosis and chronic obstructive pulmonary disease. He offered no opinion as to source of the claimant's pulmonary condition.

Dr. George Zaldivar, is a B-reader-reader and is Board-certified in internal medicine with a subspecialty in pulmonary medicine. Dr. Zaldivar offers two reports based on two separate examinations of the claimant. His examination report, based upon his April 10, 2002 examination of the claimant, notes 20 years of coal mine employment and a makes no specific finding as to the claimant's smoking history, but notes that a carboxyhemoglobin test done at the time of the examination indicates a habit of ¾ of a pack per day. (EX 8). Dr. Zaldivar described the claimant's symptoms as shortness of breath, wheezing, a productive cough, ankle edema and two pillow orthopnea.

Based on arterial blood gases, a pulmonary function study, and "radiographic evidence of early simple pneumoconiosis", Dr. Zaldivar diagnosed the claimant as suffering mild irreversible airway obstruction, moderate diffusion impairment and hypoxemia during exercise causing moderate to severe exercise limitation.

He opined that the claimant's pulmonary abnormalities are a result of the claimant's smoking habit. Dr. Zaldivar further opined that even though there appears to be radiographic evidence of pneumoconiosis, that such condition is not responsible for the claimant's pulmonary impairment. Dr. Zaldivar attributes the claimant's pulmonary impairment to bronchiolitis and pulmonary fibrosis that were caused by the claimant's smoking habit. However, Dr. Zaldivar opined that the claimant's pulmonary impairment was sufficient to prevent him from performing his last coal mine employment.

Dr. Zaldivar again examined the claimant on May 26, 2004. At that time, Dr. Zaldivar noted that the claimant's main symptoms included shortness of breath and problems with balance due to a back injury. (EX 8). At this time Dr. Zaldivar made a very specific finding as to the claimant's smoking history which included smoking 1 ½ packs of cigarettes per day and smoking a full pipe each night since 1987.

Dr. Zaldivar offered a rebuttal report, dated September 29, 2004. (EX 13). In this report, Dr. Zaldivar states that any statement indicating that there is no evidence of cardiac problems is incorrect. Dr. Zaldivar supports this statement by pointing out that congestive heart failure can be present even if the "systolic function of the left ventricle is normal" on an EKG test. Dr. Zaldivar also takes issue with Dr. Rasmussen's findings based on the available literature. In concluding, Dr. Zaldivar stated that his opinions remain the same as those offered in his earlier opinions.

Dr. Ben V. Branscomb, is a B-reader and is Board-certified in internal medicine. His examination report, based upon his examination of the claimant, on July 8, 2004, notes 18 to 19 ½ years of coal mine employment and a carboxyhemoglobin result that indicates smoking one plus packs per day of cigarettes. (EX 9).

Based on his review of the medical evidence and a negative chest X-ray, Dr. Branscomb diagnosed morbid obesity, chronic hypertension, coronary artery disease and congestive heart failure.

He opined that the claimant's pulmonary condition was not related to his coal dust exposure. Dr. Branscomb stated that the claimant's pulmonary disease has not been severe. Dr. Branscomb bases this statement on the fact that the claimant's pulmonary function testing showed a normal FVC and FEV_1 and a near normal MVV in April 2002. According to Dr. Branscomb, the claimant's testing showed no progressive loss of pulmonary function and the absence of any significant change. Dr. Branscomb opined that the claimant's medical records are insufficient to "determine precisely the cause of these more recent changes because of the lack of sufficient cardiac data."

Dr. Branscomb concluded that the claimant's condition is not a result of coal workers' pneumoconiosis. Dr. Branscomb states that there is no evidence indicating that coal dust "can cause with the pulmonary function values seen in [the claimant] a subsequent deterioration in blood gas transfer with reducing lung volume and with no change in ventilation." This occurrence is more readily attributable to heart disease.

In addressing the claimant's ability to return to his last coal mine employment, Dr. Branscomb found that the claimant is totally disabled from his last coal mining job as a result of his cardiovascular disease. Dr. Branscomb further opined that a disability level of gas exchange problems did not exist prior to 2002. The claimant's family history is significant for asthma or asthmatic bronchitis which Dr. Branscomb does not believe is caused by or aggravated by coal dust exposure. Asthma or asthmatic bronchitis do not disable the claimant from his last coal mine employment.

IV. Hospital Records & Physician Office Notes

A discharge summary from the claimant's stay at St. Francis Hospital from June 30, 2003 through July 4, 2003 is included in the record in this matter. (CX 5). The claimant was admitted by Dr. Melchor Vidal with the chief complaint of shortness of breath. The claimant was treated during this stay and underwent diagnostic testing referenced elsewhere in this Decision and Order. The claimant was discharged with the following diagnoses: "1.) congestive heart failure;

2.) acute exacerbation of COPD with probable pneumonia; 3.) lung nodule in the right apex; 4.) high blood pressure; 5.) anxiety depression; 5.) status post coronary artery bypass graft."

IV. Witness' Testimony

Dr. Dominic Gaziano was deposed on July 20, 2004 regarding his opinion of the claimant's medical condition. (CX 8). Dr. Gaziano stated that he is Board-certified in internal medicine with a subspecialty in pulmonary disease. He is also a B-reader. Dr. Gaziano has been practicing in the area of pulmonary disease for 35 years. (CX 8, pp. 4-5). Dr. Gaziano went on to discuss his examination of the claimant in March 2004. At the time of that examination, Dr. Gaziano's testing showed that the claimant was suffering from an abnormal diffusing capacity that the doctor attributed to coal workers' pneumoconiosis. (CX 8, p. 7). While Dr. Gaziano described this impairment as being only moderate, he believes that it would prevent the claimant from returning to his previous coal mine employment because such an impairment would preclude medium to heavy work. (CX 8, p. 7).

In the deposition testimony, Dr. Gaziano went on to discuss Dr. Zaldivar's findings of April 2002 and May 2004. The pulmonary function assessments at these two examination produced similar results, showing a mild obstruction. (CX 8, pp. 8-13). The claimant's weight at the time of Dr. Gaziano's examination was 231 ½ pounds. (CX 8, p. 14). Dr. Gaziano believes that this weight makes the claimant "a little overweight," not morbidly obese. (CX 8, p. 14-15). He opined that the claimant's weight would not affect his pulmonary function. (CX 8, p. 15). Dr. Gaziano went on to explain that shortness of breath can result from a variety of causes, and that the claimant's "weight excess is not terribly great and certainly would not influence the pulmonary function tests." (CX 8, p. 15).

At the time of his examination, Dr. Gaziano noted that the claimant's testing showed a diffusion impairment. (CX8, p. 22). When asked if this impairment could be caused by emphysema, Dr. Gaziano replied that emphysema could explain the changes, but for emphysema to have caused these changes, the disease process would have to have been far more severe than that seen in the claimant. (CX 8, p. 22).

In addressing Dr. Scott's finding of emphysema, Dr. Gaziano stated that such a finding was subjective. (CX 8, p. 25). To see emphysema on a chest X-ray, Dr. Gaziano believes that emphysema must be "moderate to moderately advanced" to be seen by this diagnostic tool. (CX 8, p. 25). Dr. Gaziano also does not agree with Dr. Scott's finding of "UIP." (CX 8, p. 25). Dr. Gaziano does not find the claimant's chest X-ray and symptoms to be consistent with this finding. (CX 8, p. 25).

Dr. Gaziano agrees that minimal emphysema may be present in the upper lobe, as found by Dr. Wheeler. (CX 8, p. 27). Additionally, Dr. Gaziano stated that Dr. Wheeler's findings do not exclude pneumoconiosis because "linear interstitial changes" can be pneumoconiosis. (CX 8, p. 29).

Dr. Gaziano then addressed Dr. Zaldivar's finding of asthma. Dr. Gaziano does not believe that this finding is warranted based on the pulmonary function testing because the claimant's diffusing capacity would be normal if he suffered from asthma. (CX 8, p. 30). Dr.

Gaziano also discussed Dr. Branscomb's findings. Dr. Gaziano takes issue with Dr. Branscomb's finding of morbid obesity and Dr. Gaziano believes that the claimant suffers from high blood pressure but not coronary artery disease, as found by Dr. Branscomb. (CX 8, p. 32-34). Dr. Gaziano further stated that he believes that Dr. Branscomb is assuming facts that are not included in the claimant's medical records, and therefore, Dr. Gaziano does not see any clinical evidence indicating a diagnosis of heart disease. (CX 8, p. 33-34).

In discussing the finding of congestive heart failure, Dr. Gaziano believes that if such condition were present, it would have been seen on the CT scans. (CX 8, p. 34). The finding of congestive heart failure was not apparent on any examination, but appears only in hospital records. (CX 8, p. 34).

Dr. Gaziano went on to explain that he believes that the claimant's impairment could be a result of his tobacco abuse history, as well as black lung, but the doctor believes that black lung is responsible for the dominant part of the claimant's impairment. (CX 8, p. 23). Dr. Gaziano explained that he believes that the claimant's breathing impairment resulting from the claimant's smoking history is aggravated by his black lung. (CX 8, p. 23).

In concluding, Dr. Gaziano believes that "the constellation of evidence is more likely than not that he has pneumoconiosis." (CX 8, p. 26). The claimant's pulmonary function testing and chest X-rays are consistent with a finding of coal workers' pneumoconiosis. (CX 8, p. 35). Dr. Gaziano does not believe that there is any evidence to support a finding that the claimant's condition is a result of cardiovascular disease and to attribute the claimant's condition to obesity and cardiovascular disease would be speculative. (CX 8, p. 36).

Dr. Ben V. Branscomb was also deposed in connection with this claim on August 3, 2004. (EX 11). Dr. Branscomb reviewed his credentials. (EX 11, pp. 5-14). He then went on to discuss his examination of the claimant on July 8, 2004. Dr. Branscomb stated that he does not believe that the claimant suffers from any coal mine dust induced lung disease. (EX 11, p. 15). He reached this conclusion based on the claimant's pulmonary function testing exhibiting normal results, but recently showing a mild reduction and the drop in the claimant's blood gas testing coinciding with the claimant having developed heart failure. (EX 11, pp. 15-16). Dr. Branscomb stated that the claimant has three risk factors for pulmonary problems: 1) coal mine employment; 2) tobacco exposure; and 3) asthma. (EX 11, p. 15). Later, Dr. Branscomb stated that there is no laboratory confirmation of a diagnosis of asthma, but the finding is based on the claimant's family history and the claimant's symptoms. (EX 11, p. 77).

Further, he stated that the claimant has shown a "remarkable resistance to the effects of tobacco smoking." (EX 11, p. 77). According to Dr. Branscomb, the claimant's pulmonary function testing showed significant chronic obstructive pulmonary disease with no restrictive defect. (EX 11, p. 16). Later, Dr. Branscomb stated that he believed that the claimant has a mild restrictive impairment based on the lung volume testing; however, Dr. Branscomb does not believe that this condition is a result of exposure to coal dust. (EX 11, 102-103).

Dr. Branscomb points out that in the claimant's hospitalization records, the doctors did not mention any chronic pulmonary disease which indicates to Dr. Branscomb that one is not present. (EX 11, p. 17). Dr. Branscomb also discussed the claimant's chest X-rays and CT scans which he believes do not support a diagnosis of CWP. (EX 11, p. 25-28).

The claimant's pulmonary function testing showed normal results as late as April of 2002. (EX 11, p. 28). Dr. Gaziano's testing of March 2004 showed abnormal results in a "very, very mild airway obstruction," but Dr. Branscomb does not believe that the results were low enough to produce symptoms in the claimant. (EX 11, p. 29). Dr. Branscomb reviewed all of the pulmonary function testing in the record and determined that the claimant's testing showed no restrictive impairment. (EX 11, p. 35). He stated that the most recent testing showed a "miniscule or minimal degree of airway obstruction, which responded to bronchodilator" treatment. (EX 11, p. 35).

Dr. Branscomb went on to discuss the claimant's lung volume testing. (EX 11, p. 38). Dr. Branscomb reviewed each physician's lung volume testing results and determined that the variation in the testing could be due to either the claimant's asthma or fluid in the claimant's lungs with the later explanation being the most likely. (EX 11, p. 40). In summing up the whole of the pulmonary function testing, Dr. Branscomb concluded that the claimant's results were not "consistent with any known and described effects of coal dust exposure." (EX 11, p. 40). Dr. Branscomb further concluded that the claimant's results were the result of coronary disease and heart failure. (EX 11, p. 41).

The claimant's diffusing capacity results were the subject of Dr. Branscomb's next statements. Dr. Branscomb believes that one would not expect a person with the claimant's diffusing capacity results to suffer from any symptoms. (EX 11, p. 43-44). The claimant's carboxyhemoglobin results indicated continued heavy tobacco use. (EX 11, p. 42).

Dr. Branscomb also diagnosed the claimant as suffering from morbid obesity. (EX 11, p. 51). This diagnosis would lead to changes in the claimant's pulmonary function testing as well as chest X-rays. (EX 11, p. 52). However, Dr. Branscomb stated that the claimant's obesity is not a big factor on his breathing. (EX 11, p. 79). Dr. Branscomb further diagnosed asthma or asthmatic bronchitis. (EX 11, p. 54). This diagnosis is based on the claimant's family history of asthma as well as bronchitis as a child and complaints of wheezing. (EX 11, p. 54). The lack of reversibility on the claimant's pulmonary function testing does not indicate to Dr. Branscomb that the claimant does not suffer from asthma. (EX 11, p. 56). According to the doctor, in order to properly diagnose asthma, the testing would need to be completed when the claimant was suffering from symptoms of the condition. (EX 11, p. 56). In any event, Dr. Branscomb does not believe that the claimant's asthma is causing any significant impairment. (EX 11, p. 57).

Dr. Branscomb concluded that the claimant does not suffer from pneumoconiosis based on the lack of chest X-ray evidence to support that conclusion, as well as there being no function testing to suggest a pattern of obstructive airway changes. (EX 11, pp. 58-59). The pulmonary function testing does not show a "pattern associated with coal dust exposure," but the claimant's conditions is "better explained by" his smoking history and asthma. (EX 11, p. 59).

In addressing the claimant's disability, Dr. Branscomb stated that the claimant is not totally disabled from a respiratory standpoint. (EX 11, p. 61). He attributed the claimant's pulmonary function values to heart failure. (EX 11, p. 61). This heart failure may be disabling, according to Dr. Branscomb. (EX 11, p. 62). Dr. Branscomb explained that he is unsure of the disability status of this condition because he is unaware of the treatment the claimant has received for heart failure. (EX 11, p. 112). Additionally, the claimant's asthma or asthmatic bronchitis are not very severe and is therefore, not disabling. (EX 11, p. 62). Dr. Branscomb further diagnosed an element of chronic bronchitis. (EX 11, p. 119). Dr. Branscomb attributes this condition to tobacco abuse. (EX 11, p. 119). The claimant's changes are indicative of asthma or bronchitis, not coal dust exposure. (EX 11, p. 120). Dr. Branscomb opined that these conditions could be contributing to the claimant's impairment to some degree, but the "predominant" factor in the claimant's condition is cardiac. (EX 11, p. 124).

On cross-examination, Dr. Branscomb stated that the left ventricular failure is a respiratory condition. (EX 11, p. 65). Dr. Branscomb later explained this statement by saying that the claimant's diffusing capacity impairment is caused by his cardiac condition because the impairment caused by such a condition is different from that caused by lung disease. (EX 11, p. 114). The claimant's condition presents as a cardiac disease. (EX 11, p. 114). In further discussing this condition, Dr. Branscomb stated that he did not find confirmation of this condition on the CT scans or chest X-rays. (EX 11, p. 85). Dr. Branscomb believes that this condition would prevent the claimant from performing his last coal mine employment. (EX 11, p. 65). Dr. Branscomb agreed that a diagnosis of left ventricular failure is speculative based on the record as it currently exists. (EX 11, p. 86). Later however, Dr. Branscomb stated that the discharge summary from the claimant's July 2003 hospital stay supports a conclusion that the claimant suffers from heart disease. (EX 11, p. 105). Dr. Branscomb changed his position and later stated that the diagnosis of heart failure is not speculative and that there is no question that the claimant suffers from heart failure and severe heart disease. (EX 11, p. 115).

Dr. Branscomb also discussed Dr. Zaldivar's May 2004 examination of the claimant. (EX 11, 66). Dr. Branscomb disagrees with Dr. Zaldivar's conclusions, but would agree that the claimant suffers from a diffusing capacity impairment but would characterize that impairment as mild rather than moderate. (EX 11, p. 67 & 83). Dr. Zaldivar's testing did show a moderate gas transfer impairment. (EX 11, p. 84). According to Dr. Branscomb, the pulmonary function testing of Drs. Zaldivar, Rasmussen and Gaziano do not show asthma. (EX 11, p. 69).

In discussing Dr. Zaldivar's April 2002 examination, Dr. Branscomb agreed that the claimant's "degree of airway obstruction by breathing tests is in itself not sufficient to cause the degree of hypoxemia which he had." (EX 11, p. 88). However, Dr. Branscomb disagreed with Dr. Zaldivar's conclusion that "the hypoxemia is caused by either pulmonary fibrosis or pulmonary emboli." (EX 11, p. 90).

Dr. Branscomb was again deposed in connection with this matter on September 30, 2004. (EX 12). This deposition was offered in response to Dr. Rasmussen's supplemental report. Dr. Branscomb stated that his original opinions did not change after reviewing Dr. Rasmussen's report. (EX 12, p. 6). Dr. Branscomb first addressed his diagnosis of asthma stating that the claimant has a history of shortness of breath occurring back into the 1980s with chronic cough and wheezing. (EX 11, p. 6). Dr. Branscomb supported his conclusion by stating that asthma

had been diagnosed a couple of times along with congestive heart failure and coronary artery disease. (EX 12, p. 6). Dr. Branscomb also stated that any chronic pulmonary disease sufficiently severe to prevent the claimant from returning to work would not be overlooked in nine hospitalization reports as is the case with the claimant. (EX 12, p. 7).

Dr. Branscomb then went on to discuss the claimant's coronary artery disease. This condition was first diagnosed in June 1993 and congestive heart failure being repeatedly diagnosed since April 2002. (EX 12, p. 7). Dr. Branscomb supported this conclusion by the fact that the claimant is taking medication for congestive heart failure. (EX 12, p. 8). Dr. Branscomb took issue with Dr. Rasmussen using the claimant's DLCO value to support his conclusion. (EX 12, p. 11). Dr. Branscomb takes issue with this because Dr. Rasmussen did not correct the diffusing capacity for alveolar volume. (EX 12, p. 11).

Dr. Branscomb also disagrees with the publications and physiological findings of Dr. Rasmussen. (EX 12, p. 15). Dr. Branscomb does not believe that the support cited by Dr. Rasmussen is what is stated in the cited papers or does not believe that the premises cited are generally accepted. (EX 12, p. 15). Dr. Branscomb concluded that the claimant's fluctuation in findings point to the presence of heart disease. (EX 11, p. 16). There is also plenty of clinical evidence of heart failure. (EX 12, p. 17). Dr. Branscomb concluded that the physiological pattern described in the claimant is "highly characteristic" of congestive heart failure. (EX 12, p. 17).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). *See Lane v. Union Carbide Corp.*, 105 F.3d 166, 170 (4th Cir. 1997). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3rd Cir. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP,* 9 B.L.R. 1-1 (1986). Moreover, "[T]he presence of evidence favorable to the claimant or even a tie in the proof will not suffice to meet that burden." *Eastover Mining Co. v. Director, OWCP [Williams]*, ___ F.3d ___, No. 01-4064 (6th Cir. July 31, 2003), *citing Greenwhich Collieries [Ondecko]*, 512 U.S. 267 at 281; *see also Peabody Coal Co. v. Odom*, __ F.3d ___, 2003 WL 21998333 (6th Cir. Aug. 25, 2003).

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment."[11] 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.[12]

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[13] Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

"…[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14

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[11] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1362; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995) at 314-315. In *Henley v. Cowan and Co*., 21 B.L.R. 1-148 (May 11, 1999), the Board holds that aggravation of a pulmonary condition by dust exposure in coal mine employment must be "significant and permanent" in order to qualify as CWP, under the Act.

[12] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure. (Emphasis added).

[13] The definition of pneumoconiosis, in 20 C.F.R.§ 718.201, does not contain a requirement that "coal dust specific diseases …attain the status of an "impairment" to be so classified. The definition is satisfied "whenever one of these diseases is present in the miner at a detectable level; whether or not the particular disease exists to such an extent as to become compensable is a separate question." Moreover, the legal definition of pneumoconiosis "encompasses a wide variety of conditions; among those are diseases whose etiology is not the inhalation of coal dust, but who's respiratory and pulmonary symptomatology have nevertheless been made worse by coal dust exposure. *See, e.g., Warth*, 60 F.3d at 175." *Clinchfield Coal v. Fuller*, 180 F.3d 622 (4th Cir. June 25, 1999) at 625.

B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing, Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[14] 20 C.F.R. § 718.202(a)(4).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, i.e. X-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal co. v. Williams,* 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim field after January 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence. 20 C.F.R. § 718.202(a)(1). The correlation between "physiologic and radiographic abnormalities is poor" in cases involving CWP. "[W]here two or more X-ray reports are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." *Id.; Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985)." (Emphasis added). (Fact one is Board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16

[14] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel,* 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

B.L.R. 1-31 (1991) at 1-37. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985).

A judge is not required to defer to the numerical superiority of X-ray evidence, although it is within his or her discretion to do so. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). This is particularly so where the majority of negative readings are by the most qualified physicians. *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344(1985); *Melnick v. Consolidation Coal Co. & Director, OWCP,* 16 B.L.R. 1-31, 1-37 (1991).

There are 10 readings of 8 chest X-rays included in this claim. One of the readings was made for quality purposes only and therefore is not relevant to the determination of the existence of pneumoconiosis. Of the remaining chest X-rays, two are positive for the existence of pneumoconiosis and five are negative for the existence of pneumoconiosis. One of the positive readings was rendered by a dually qualified physician and the other by a physician who is board certified in pulmonary disease and is a B-reader. Three of the negative readings were rendered by physicians who are board certified radiologists as well as B-readers and the other two were rendered by a physician who is board certified in internal medicine and is a B-reader. The remaining two interpretations were made during a hospital stay and make no mention of the existence or absence of pneumoconiosis.

With the exception of the "1/1" reading by Dr. Patel of the 9/3/02 X-ray, all the readings from 1992 through early 2004 do not find clinical CWP. Dr. Patel's reading was not supported by Dr. Scott, an equally qualified reader. Although a B-reader found a 3/4/04 X-ray positive, a dual-qualified reader found an X-ray taken two months later (5/26/04) negative. The most recent X-ray is negative and two X-rays taken during hospitalizations in 2003 do not mention clinical or legal CWP.

Based on the foregoing, I find that the claimant has failed to establish by a preponderance of chest X-ray evidence the existence of clinical or legal pneumoconiosis. I also base this finding on the majority of negative readings and the qualifications of the physicians who interpreted the claimant's chest X-rays as being negative. Therefore, I find that the claimant has failed to establish the existence of pneumoconiosis by a preponderance of the chest X-ray evidence.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms and a physical examination constitute adequately documented medical pinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the

documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it.[15] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Because of their various Board-certifications, B-reader status, and expertise, as noted above, I rank Drs. Rasmussen, Gaziano, Zaldivar, and Dr. Branscomb equally qualified, given the latter's significant experience.

While the courts and the Board earlier recognized that there may be a practical distinction between a physician who merely examines a miner and one who is one of his "treating" physicians, that preference has largely been obviated, except in the Third Circuit.[16] In *Black and Decker Disability Plan v. Nord,* Case No. 02-469, ___ U.S. ___, ___ S.Ct. ___ (May 27, 2003), the Court held ERISA plan administrators (Courts) need not give special deference to the opinion of a treating physician. Dr. Vidal was Mr. Jenkins' treating physician for 19 years. As such, his opinion must be considered under the criteria of section 718.104(d).[17]

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[15] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltar Coal Corp.*, 6 B.L.R. 1-1291 (1984)…"

[16] "Treatment" means "the management and care of a patient for the purpose of combating disease or disorder." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, p. 1736 (28th Ed. 1994). "Examination" means "inspection, palpitation, auscultation, percussion, or other means of investigation, especially for diagnosing disease, qualified according to the methods employed, as physical examination, radiological examination, diagnostic imaging examination, or cystoscopic examination." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, p. 589 (28th Ed. 1994). *Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1989); *Jones v. Badger Coal Co.*, 21 B.L.A. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*) (Proper for Judge to accord greater weight to treating physician over non-examining doctors). *Lango v. Director, OWCP*, 104 F.3d 573 (3rd Cir. 1997). The Court wrote that while there is "some question about the extent of reliance to be given a treating physician's opinion when there is conflicting evidence, *compare Brown v. Rock Creek Mining Co*., 996 F.2d 812, 816 (6th Cir. 1993)(opinions of treating physicians are clearly entitled to greater weight than those of non-treating physicians), "a judge may require "the treating physician to provide more than a conclusory statement (before finding pneumoconiosis contributed to the miner's death)." *But see, Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997), wherein the Court held that a rule of absolute deference to treating and examining physicians is contrary to its precedents. *See also, Amax Coal Co. v. Franklin,* 957 F.2d 355 (7th Cir. 1992) where the court criticized the administrative law judge's crediting of a treating general practitioner, with no apparent knowledge of CWP and no showing that his ability to observe the claimant over an extended time period was essential to understanding the disease, over an examining Board-certified pulmonary specialist bordered on the irrational. The Court called judge's deference to the "treating physician" over a non-treating specialist unwarranted in light of decisions such as *Richardson v. Perales*, 402 U.S. 389, 91 S.Ct. 1420, 28 L.Ed.2d 842 (1971); *Garrison v. Heckler*, 765 F.3d 710, 713-15 (7th Cir. 1985); and, *DeFrancesco v. Bowen*, 867 F.2d 1040, 1043 (1989). *Consolidation Coal Co. v. Director, OWCP [Held]*, ___ F.3d ___, Case No. 99-2507 (4th Cir. Dec. 20, 2000)(with Dissent). Improper to accord greater weight to the opinion of treating physician because he had treated and examined claimant each year over the past ten years. In *Grizzle v. Pickland Mather & Co.*, 994 F.2d 1093 (4th Cir. 1993), we clearly stated we had not fashioned any presumption or requirement that the treating physicians' opinions be given greater weight. While the treating physician's opinion here may have been entitled to "special consideration", it was not entitled to the greater weight accorded.

[17] § 718.104(d) Treating Physician (Jan. 19, 2001). In weighing the medical evidence of record relevant to whether the miner suffers, or suffered, from pneumoconiosis, whether the pneumoconiosis arose out of coal mine

While I believe that the claimant and Dr. Vidal have established a relationship that would entitled Dr. Vidal's opinion to greater weight as the claimant's treating physician, I find that Dr. Vidal's opinion is not entitled to such deference because Dr. Vidal does not offer any support for his conclusory statements. Dr. Vidal states a conclusion in his letter regarding the claimant's condition but does not support that statement with any objective testing or specific statements or any rationale whatsoever for his findings. Therefore, I find Dr. Vidal's opinion to be entitled to no greater weight than the other physicians of record in this matter. Moreover, his qualifications are not of record.

It is rational to credit more recent evidence, solely on the basis of recency, only if it shows the miner's condition has progressed or worsened. The court reasoned that, because it is impossible to reconcile conflicting evidence based on its chronological order if the evidence shows that a miner's condition has improved, inasmuch as pneumoconiosis is a progressive disease and claimants cannot get better, "[e]ither the earlier or later result must be wrong, and it is just as likely that the later evidence is faulty as the earlier…" *Adkins v. Director, OWCP*, 958 F.2d 49, 16 B.L.R. 2-61 (4th Cir. 1992). *See also, Thorn v. Itmann Coal Co.,* 3 F.3d 713, 18 B.L.R. 2-16 (4th Cir. 1993).

It is proper for an administrative law judge to accord greater weight to a physician who "integrated all of the objective evidence" more than contrary physicians of record, particularly where he considered tests results showing diffusion impairment, reversibility studies, and blood gas readings. *Midland Coal Co. v. Director, OWCP [Shores]*, 358 F.3d 486 (7th Cir. 2004).

I have reviewed all of the medical opinion evidence and find that the claimant has not established the existence of pneumoconiosis by a preponderance of the physician opinion evidence. In doing so, I have considered the three readings of the two CT scans in this matter. I have accorded the appropriate weight to these scans and find that while they do not support a finding of pneumoconiosis, the remainder of the physician opinion evidence does support such a finding.

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employment, and whether the miner is, or was totally disabled by pneumoconiosis or died due to pneumoconiosis, the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. Specifically, the adjudication officer shall take into consideration the following factors in weighing the opinion of the miner's treating physician:

(1) Nature of relationship. The opinion of a physician who has treated the miner for respiratory or pulmonary conditions is entitled to more weight than a physician who has treated the miner for non-respiratory conditions;

(2) Duration of relationship. The length of the treatment relationship demonstrates whether the physician has observed the miner long enough to obtain a superior understanding of his or her condition;

(3) Frequency of treatment. The frequency of physician-patient visits demonstrates whether the physician has observed the miner often enough to obtain a superior understanding of his or her condition; and

(4) Extent of treatment. The types of testing and examinations conducted during the treatment relationship demonstrate whether the physician has obtained superior and relevant information concerning the miner's condition.

(5) In the absence of contrary probative evidence, the adjudication office shall accept the statement of a physician with regard to the factors listed in paragraphs (d)(1) through (4) of this section. In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officers' decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

Drs. Rasmussen, Gaziano, Vidal and Zaldivar all found the existence of clinical pneumoconiosis. (DX 13; CX 1, 6, 7, 8; EX 8, 13). Drs. Rasmussen, Gaziano and Vidal found the existence of clinical pneumoconiosis based on the claimant's employment history and positive chest X-ray interpretations. Dr. Zaldivar found radiographic evidence of early simple coal workers' pneumoconiosis**.** Dr. Vidal relied primarily upon the pulmonologists' findings and positive X-rays. The pulmonologists relied primarily upon positive X-ray readings; Dr. Gaziano, upon his own reading and Rasmussen on Dr. Patel's reading. I do not find the X-rays, particularly when viewed in light of the negative CT readings, establish clinical CWP.

Drs. Rasmussen and Gaziano attributed the miner's COPD to his smoking and primarily coal mine dust exposure. Drs. Zaldivar and Branscomb found the miner's pulmonary afflictions due solely to smoking and cardiac disease, i.e., CHF, CAD. Dr. Vidal's opinion is unreasoned although it does support a finding of heart disease. As Dr. Branscomb so aptly pointed out, the records clearly demonstrate the miner had significant heart disease, even having undergone a CABG. I find the discounting of such heart afflictions, by Drs. Rasmussen and Gaziano, which according to Dr. Branscomb affected the miner's breathing, detract from the worth of the formers' opinions, despite Dr. Rasmussen's normal 2002 EKG reading. To the contrary, Drs. Zaldivar and Branscomb recognized the miner's heart afflictions and attribute his pulmonary problems, i.e., chronic bronchitis, irreversible obstruction, to his long smoking history and heart disease.[18] The opinions of Drs. Zaldivar and Branscomb are more aligned with the objective medical data. I find that legal CWP is not established by medical opinion evidence and, at best, the medical opinions are in equipoise, when considered with the remaining objective medical evidence.

I have weighed all of the evidence pertaining to the existence of pneumoconiosis together and find that the claimant has not established the existence of clinical or legal pneumoconiosis

I find the claimant has not met his burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff'g sub. nom. Greenwich Collieries v. Director, OWCP,* 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since the miner had ten years or more of coal mine employment, ordinarily he would receive the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. However, here the miner has failed to establish the existence of the disease so causation is moot.

[18] I observe that at one point Dr. Branscomb indicated the cardiac data was insufficient; at other times he did not.

D. Existence of total disability due to pneumoconiosis

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b) .[19] Section 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony.[20] Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. All of the citations to congestive heart failure in this claimant indicate left ventricular heart failure and not right-sided congestive heart failure. Section 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miners' claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. More weight may be accorded to the results of a recent ventilatory study over those of an earlier study. *Coleman v. Ramey Coal Co.,* 18 B.L.R. 1-9 (1993).

None of the pulmonary function studies in this matter produced qualifying results under the applicable Regulations. Therefore, I find that the claimant has failed to establish the existence of totally disabling respiratory condition by a preponderance of the pulmonary function study evidence.

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(b)(2)(ii). More weight may be accorded to the results of a recent blood gas study over one which was conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993).

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[19] § 718.204 (Effective Jan. 19, 2001). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states: (a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease shall be considered in determining whether a miner is or was totally disabled due to pneumoconiosis.

[20] In a living miner's claim, lay testimony "is not sufficient, in and of itself, to establish disability." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994). See 20 C.F.R. § 718.204(d)(5)(living miner's statements or testimony insufficient alone to establish total disability).

Only one of the claimant's arterial blood gas studies qualifies for disability status under the applicable Regulations. The qualifying test is the oldest of the four tests. Therefore, I have accorded greater weight to the more recent tests and find that the claimant has failed to establish the existence of a totally disabling respiratory impairment by a preponderance of the arterial blood gas testing.

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medial judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition presents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable or gainful work. § 718.204(b). Under this subsection, "…all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP,* 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

I find that the miner's last coal mining positions required heavy manual labor. Because the claimant's symptoms render him unable to walk short distances and climb, I find he is incapable of performing his prior coal mine employment.

There is consensus among the physicians of record that the claimant would be unable to return to his last coal mine employment. Drs. Rasmussen and Gaziano attribute the majority of the claimant's impairment to his coal mine employment. (DX 13 & CX 1, 8). Dr. Zaldivar attributes the claimant's disability to bronchiolitis and pulmonary fibrosis as a result of the claimant's smoking history. (EX 8). Dr. Branscomb found that the claimant is totally disabled as a result of his cardiac condition. (EX 9, 11). Other than Dr. Vidal, the physicians agree the miner is totally disabled.

The Fourth Circuit rule is that "nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis." *Jewell Smokeless Coal Corp. v. Street,* 42 F.3D 241 (4th Cir. 1994). In *Milburn Colliery Co. v. Director, OWCP, [Hicks]*, 21 B.L.R. 2-323, 138 F.3d 524, Case No. 96-2438 (4th Cir. Mar. 6, 1998) *citing Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994), the Court had "rejected the argument that '[a] miner need only establish that he has a total disability, which may be due to pneumoconiosis in combination with nonrespiratory and nonpulmonary impairments." Even if it is determined that claimant suffers from a totally disabling respiratory condition, he "will not be eligible for benefits if he would have been totally disabled to the same degree because of his other health problems." *Id.* at 534.

I find the claimant has met his burden of proof in establishing the existence of total disability. *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994), *aff'g sub. Nom. Greenwich Colleries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

E. Cause of total disability

The revised regulation, 20 C.F.R. § 718.20(c)(1), requires a claimant establish his pneumoconiosis is a "substantially contributing cause" of his totally disabling respiratory or pulmonary disability.[21] The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) and(ii), adding the words "material" and "materially", results in "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." 65 Fed. Reg. No. 245, 799946 (Dec. 20, 2000).[22]

The Fourth Circuit Court of Appeals requires that pneumoconiosis be a "contributing cause" of the claimant's total disability.[23] *Toler v. Eastern Associated Coal Co.*, 43 F.3d 109, 112 (4th Cir. 1995); *Jewel Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994). In *Street*, the Court emphasized the steps by which the cause of total disability may be determined by directing "the Administrative Law Judge [to] determine whether [the claimant] suffers from a respirator or pulmonary impairment that is totally disabling and whether [the claimant's] pneumoconiosis contributes to this disability." *Street*, 42 F.3d 241 at 245.

"A claimant must be totally disabled due to pneumoconiosis and any other respiratory or pulmonary disease, not due to other non-respiratory or non-pulmonary ailments, in order to qualify for benefits." *Beatty v. Danri Corp. & Triangle Enterprises*, 16 B.L.R. 1-11 (1991) *aff'd* 49 F.3d 993 (3d Cir. 1995) *accord Jewell Smokeless Coal Corp.* So one whose disability is only 10% attributable to pneumoconiosis would be unable to recover benefits if his completely unrelated physical problems (i.e., stroke) created 90% of his total disability. The fact that a physician does not explain how he could distinguish between disability due to coal mining and cigarette smoking or refer to evidence which supports his total disability opinion may make this opinion "unreasoned." *Gilliam v. G&O Coal Co.*, 7 B.L.R. 1-59 (1984).

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[21] This standard is more consistent with the Third Circuit's pre-amendment "substantial contributor" standard set forth in *Bonessa v. U.S. Steel Corp*., 884 F.2d 726, 13 B.L.R. 2-23 (3d Cir. 1989) than the Fourth Circuit's "contributing cause" standard set forth in *Robinson v. Picklands Mather & Co./ Leslie Coal Co. v. Director, OWCP*, 14 B.L.R. 2-68 at 2-76, 914 F.2d 35, 38 (4th Cir. 1990).

[22] Effective January 19, 2001, § 718.204(a) states, in pertinent part:

> For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

[23] *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990).

Osborne v. Westmoreland Coal Co., ___ B.L.R. ___, BRB No. 96-1523 BLA (April 30, 1998). Proper for judge to accord less weight to physicians' opinions which found that pneumoconiosis did not contribute to the miner's disability on the grounds that the physicians did not diagnose pneumoconiosis.

There is evidence of record that claimant's respiratory disability is due, in part, to his undisputed history of cigarette smoking. However, to qualify for Black Lung benefits, the claimant need not prove that pneumoconiosis is the "sole" or "direct" cause of his respiratory disability, but rather that it has contributed to his disability. *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 914 F.2d 35, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-76. *Jones v. Badger Coal Co.*, 21 B.L.R. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*). There is no requirement that doctors "specifically apportion the effects of the miner's smoking and his dust exposure in coal mine employment upon the miner's condition." *Jones v. Badger Coal Co.*, 21 B.L.R. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*) *citing generally, Gorzalka v. Big Horn Coal Co.*, 16 B.L.R. 1-48 (1990).

If the claimant would have been disabled to the same degree and by the same time in his life had he never been a miner, then benefits cannot be awarded. *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Picklands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990).[24]

Drs. Rasmussen and Gaziano attribute a majority of the claimant's pulmonary disability to his coal workers' pneumoconiosis. (DX 13 & CX 8). Dr. Zaldivar attributes the claimant's pulmonary impairment to bronchiolitis and pulmonary fibrosis as a result of the claimant's smoking history. (EX 8). Dr. Branscomb attributes the claimant's impairment to his cardiac condition. (EX 9 & 11).

Given the evidence does not establish clinical or legal CWP, I give little, if any, weight to the two physician opinions concluding the miner's disability is due to CWP. I find Drs. Branscomb and Zaldivar's consideration of the miner's heart afflictions entitles their opinions to greater weight.

Based on the foregoing, I find that the claimant has not established that coal workers' pneumoconiosis is a contributing cause of his totally disabling respiratory impairment.

CONCLUSIONS

In conclusion, the claimant has not established pneumoconiosis, as defined by the Act and Regulations or that pneumoconiosis, if any, arose out of his coal mine employment. The claimant is totally disabled. He has not established his total disability is due to pneumoconiosis. He is therefore not entitled to benefits.

[24] "By adopting the 'necessary condition' analysis of the Seventh Circuit in *Robinson*, we addressed those claim…in which pneumoconiosis has played only a *de minimis* part. *Robinson*, 914 F.2d at 38, n. 5." *Dehue Coal Co. v. Ballard*, 65 F.3d 1189, 1195 n. 8 (4th Cir. 1995).

ORDER[25]

It is ordered that the claim of FRED R. JENKINS for benefits under the Black Lung Benefits Act is hereby DENIED.

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RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS (Effective Jan. 19, 2001): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or receipt by) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.[26]

[25] § 725.478 Filing and service of decision and order (Change effective Jan. 19, 2001). Upon receipt of a decision and order by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.

[26] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001). (d) Regardless of any defect in service**,** actual receipt of the decision is sufficient to commence the 30-day period for requesting reconsideration or appealing the decision.